BlueCross BlueShield Federal Employee Program.

ULTOMIRIS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Ultomiris

(ravulizumab-cwvz)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Is the prescriber enrolled in the Ultomiris REMS program? ❑Yes ❑No
2. What is the patient's diagnosis?

❑Atypical hemolytic uremic syndrome (aHUS)

a. Does the patient have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? ❑Yes ❑No

b. Will this medication be used in combination with another Prior Authorization (PA) medication for atypical hemolytic uremic syndrome (aHUS) (e.g., Soliris (eculizumab))? ❑Yes***** ❑No

If YES, please specify the medication: _____

c. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No

ii. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*****

If NO, is urgent Ultomiris therapy indicated for this patient (e.g., the risks of delaying treatment with Ultomiris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No

ii. Has the patient experienced unacceptable toxicity while on Ultomiris therapy? ❑Yes ❑No

❑Neuromyelitis optica spectrum disorder (NMOSD)

a. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for neuromyelitis optica spectrum disorder (NMOSD) (e.g., Soliris (eculizumab))? ❑Yes***** ❑No

If YES, please specify the medication: _____

b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ❑Yes ❑No

ii. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*****

If NO, is urgent Ultomiris therapy indicated for this patient (e.g. the risks of delaying treatment with Ultomiris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had fewer relapses while on Ultomiris therapy? ❑Yes ❑No

ii. Has the patient experienced unacceptable toxicity while on Ultomiris therapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Generalized myasthenia gravis (gMG)

a. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis (gMG) (e.g., Soliris (eculizumab))? ❑Yes***** ❑No

If YES, specify the medication: _____

b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a positive serologic test for anti-AChR antibodies? ❑Yes ❑No

ii. What is the patient's MGFA (Myasthenia Gravis Foundation of America) clinical classification? ***Select answer below:***

❑Class I ❑Class II to IV ❑Class V ❑Unknown

iii. **If Class II to IV**: Does the patient have a documented baseline *****MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 6? ❑Yes ❑No

****MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

iv. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*****

If NO, is urgent Ultomiris therapy indicated for this patient (e.g., the risks of delaying treatment with Ultomiris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

v. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ❑Yes ❑No

vi. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one immunosuppressive therapy either in combination or as monotherapy, such as: azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, or cyclophosphamide? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Is there a documented decrease of the *****MG-Activities of Daily Living (MG-ADL) total score from baseline of greater than or equal to 2 points? ❑Yes ❑No

****MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

ii. Has the patient experienced unacceptable toxicity while on Ultomiris therapy? ❑Yes ❑No

❑Paroxysmal nocturnal hemoglobinuria (PNH)

a. Will this medication be used in combination with another Prior Authorization (PA) medication for paroxysmal nocturnal hemoglobinuria (PNH) (e.g., Empaveli (pegcetacoplan), Soliris (eculizumab))? ❑Yes***** ❑No

If YES, specify the medication: _____

b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No

ii. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*****

If NO, is urgent Ultomiris therapy indicated for this patient (e.g., the risks of delaying treatment with Ultomiris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No

ii. Has the patient experienced unacceptable toxicity while on Ultomiris therapy? ❑Yes ❑No

❑None of the above

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Ultomiris – FEP MD Fax Form Revised 5/17/2024